Calendar No. 594

100TH CONGRESS
2d Session

SENATE

REPORT
100-304

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1987

MARCH 22 (legislative day, MARCH 21), 1988.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 3235]

The Committee on Labor and Human Resources, to which was referred the bill (H.R. 3235) having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill (as amended by the substitute) do pass.

CONTENTS

I. The Bill as Reported

[H.R. 3235, 100th Cong., 2d sess.]

AN ACT To amend the Public Health Service Act to revise the program of assistance for health maintenance organizations

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE, REFERENCE.

(a) Short Title.—This Act may be cited as the "Health Maintenance Organization Amendments of 1987".

(b) Reference.—Whenever in this act (other than in section 6(a)) an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

SEC. 2. ORGANIZATIONAL STRUCTURE.

Section 1301(a) (42 U.S.C. 300e(a)) is amended by striking out "legal entity" and inserting in lieu thereof "public or private entity which is organized under the laws of any State and".

SEC. 3. DEDUCTIONS.

Section 1301(b)(1) (42 U.S.C. 300e(b)(1)) is amended by adding after the second sentence the following: "If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A), the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician.".

SEC. 4. PHYSICIAN SERVICES.

(a) General Rule.—Section 1301(b)(3)(A) (42 U.S.C. 300e(b)(3)(A)) is amended by striking out "the services of a physician which are provided as basic health services shall be provided" and insert in lieu thereof "at least 90 percent of the services of a physician which are provided as basic health services shall be provided".

(b) Dual-Choice.—Section 1310(b) (42 U.S.C. 300e–9(b)) is amended—

(1) in paragraph (1), by inserting before the comma at the end the following: "and provides at least 90 percent of such services through physicians described in section 1301(b)(3)(A)", and

(2) in paragraph (2), by inserting before the comma at the end the following: "and provides no more than 10 percent of such services through physicians who are not described in section 1301(b)(3)(A)".

SEC. 5. ORGANIZATION.

(a) Risk of Insolvency.—Section 1301(c)(1)(A) (42 U.S.C. 300e(c)(1)(A)) is amended by inserting after the words "fiscally sound operation" the following: "which, taking into consideration the fiscal soundness of an affiliated organization, if any, which owns such health maintenance organization, is satisfactory to the Secretary,".

(b) REPEAL.—Paragraph (5) of seciton 1301(e) (42 U.S.C. 300e(c)) is repealed and paragraphs (6) through (9) are redesignated as paragraphs (5) through (8), respectively.

SEC. 6. DEFINITIONS.

(a) ORGAN TRANSPLANTS.—Subsection (b) of section 812 of the Health Maintenance Organization Amendments of 1986 (42 U.S.C. 300e–1 note) is repealed.

"(b) COMMUNITY RATING.—

"(1) The third sentence of section 1302(8)(C) (42 U.S.C. 300e–1(8)(C)) is amended to read as follows: 'if a health maintenance organization is to fix rates of payment for individuals and families by groups, it shall—".

"(i)(I) classify all of the members of the organization into classes based on factors which the health maintenance organization determines predict the differences in the use of health services by the individuals or families in each class and which have not been disapproved by the Secretary.

"(II) determine its revenue requirements for providing services to the members of each class established under subclause (I), and

"(III) fix the rates of payments for the individuals and families of a group on the basis of a composite of the organization's revenue requirements determined under subclause (II) for providing services to them as members of the classes established under subclause (I), or

"(ii) fix the rates of payments for the individuals and families of a group on the basis of the organization's revenue requirements for providing services to the group, except that the rates of payments for the individuals and families of a group of less than 100 persons may not be fixed at rates greater than 110 percent of the rate that would be fixed for such individuals and families under subparagraph (B) or clause (i) of this subparagraph.".

(2) Section 1302(8)(C) (42 U.S.C. 300e–1(8)(C)) is amended by adding at the end thereof the following new sentence: "If a health maintenance organization is to fix rates of payment for a group under clause (ii), it shall, on request of the entity with which it contracts to provide services to such group, disclose to that entity the method and data used in calculating the rates of payment.".

SEC. 7. EMPLOYEES' HEALTH BENEFIT PLANS.

(a) STATES AND POLITICAL SUBDIVISIONS.—

(1) Section 1310(b) (42 U.S.C. 300e–9(b)) is amended (A) by striking out "subject to subsection (a)" and inserting in lieu thereof "or a State or political subdivision", and (B) by striking out "employer pursuant" and inserting in lieu thereof "employer or State or political subdivision pursuant".

(2) Section 1310(c) (42 U.S.C. 300e–9(c)) is amended by inserting "or State or political subdivision" after "employer" each place it occurs.

(b) DISCRIMINATION.—Section 1310(c) (42 U.S.C. 300e–9(c)) is amended by adding at the end the following: "If a health benefits plan offered by an employer or a State or political subdivision

under subsection (a) includes contributions for services offered under the plan, the employer or State or political subdivision shall make a contribution under the plan for services offered by a qualified health maintenance organization in an amount which does not financially discriminate against an employee who enrolls in such organization. For purposes of the preceding sentence, an employer's contribution does not financially discriminate if the employer's method of determining the contributions on behalf of all employees is reasonable and is designed to assure employees a fair choice among health benefits plans.".

(c) APPLICATION.—Nothing in section 1310 of the Public Health Service Act (42 U.S.C. 300e–9) shall be construed to supersede any provision of a collective bargaining agreement in effect on the date of enactment of this Act.

SEC. 8. RESTRICTIVE STATE LAWS.

Section 1311(a)(1) (42 U.S.C. 300e–10(a)(1)) is amended by striking out "or" at the end of subparagraph (C), by striking out ", and" at the end of subparagraph (D) and inserting in lieu thereof ", or", and by adding at the end the following:

"(E) imposes requirements which would prohibit the entity from complying with the requirements of this title, and".

II. PURPOSE AND SUMMARY

The purpose of the bill is to modify Title XIII of the Public Health Service Act, known as the Health Maintenance Organizations (HMO) law, to provide greater flexibility in the way HMOs are organized and operated. The bill also modifies the contribution which the HMO law requires employers to make on behalf of their employees to HMOs selected by their employees.

III. BACKGROUND AND NEED FOR THE LEGISLATION

The bill addresses a number of issues that have arisen in recent years regarding the requirements that the federal government imposes on HMOs that seek federal qualification and on the employers that offer federally qualified HMOs to their employees. In response to the criticism that the law's requirements are too rigid, the bill would give HMOs additional flexibility in their corporate structure, the organization of their physician services, and the rating systems by which they establish their premiums for enrolled members. In response to criticism of the requirement in current regulations regarding employer contributions to HMOs on behalf of their employees, the bill would clarify for employers the level of contribution they must make on behalf of employees under their health benefits plans when employees enroll in HMOs as opposed to the other health benefits options offered by the employer.

The HMO law has proven to be one of our most important public health statutes. These amendments are a further fine tuning of that law.

Title XIII was established in 1973 and has been modified on several occasions. The law has helped to develop hundreds of prepaid health care organizations that have changed the face of medical care in this country. HMOs have successfully controlled health

care costs and, by their very presence, forced other providers and insurers to become more efficient and less costly.

The federal qualification process, by which the Department of Health and Human Services reviews applications from HMOs to become federally qualified, remains at the heart of the law today. The compliance by HMOs with the requirements of their federal qualification provides assurance to employers and their employees that HMOs which serve them will be fiscally sound and well managed and will provide good quality health care in an economical way.

The bill meets the dual objectives of providing greater flexibility to HMOs and employers while maintaining a sound federal qualification program. The legislation gives HMOs and employers the additional flexibility they need to respond to the ever-changing health care market place. However, the bill will assure that federally qualified HMOs will serve as the benchmark for the rest of the field.

The HMO law plays a major role in our health care system today. This bill will improve the law.

IV. Section-by-Section Analysis and Discussion

Section 1. Short title and reference

The short title of the bill is the "Health Maintenance Organization Amendments of 1987".

Section 2. Organizational structure

Current law.—Section 1301(a) requires that an HMO be a separate "legal entity." It cannot be a part of a larger corporation or operate any other business, such as an insurance company, as a part of it.

The bill.—Section 1301(a) is amended to permit both of these corporate structures. Section 2 of H.R. 3235 revises the definition of an HMO by replacing the current term "legal entity" with the language "public or private entity which is organized under the laws of any state."

Committee views.—HMOs and health insurance companies can more effectively compete if each can offer a range of coverage options. It is unnecessary and too confusing for employers to have to deal with separate legal entities when a single corporation could offer several options including an HMO, a PPO, an indemnity plan, or a self-insurance administrative arrangement. Similar language has been implemented in Medicare for HMO-like entities called "Competitive Medical Plans." Both insurance companies and HMOs benefit from this change: insurance companies can have an HMO as a line of business, and HMOs can operate other health care models.

This amendment is intended to change some of the criteria to be applied during HHS review of an applicant for Federal qualification when the HMO operations are located in a component of a larger entity. Currently, HHS reviews all activities of an entity in determining whether the Federal qualifications are met. As a result, an HMO that wants to establish a distinct health benefits plan that will offer fewer than the level of benefits required for

federal HMO qualification must operate that plan through an independent corporation. In contrast, when HHS reviews an application for a competitive medical plan (CMP) under Section 1876 of the Social Security Act and the CMP is an operating component of a larger corporate entity, HHS will look only to the CMP component of the entity to determine if the applicable health care delivery system requirements are satisfied. Thus, another component of the entity could engage in an activity outside the scope of the Act, such as offering fewer than the required level of benefits, without jeopardizing the organization's CMP certification.

This amendment is intended to provide for a similar review for federal qualification as an HMO. To accomplish this objective, the bill replaces the existing language in section 1301 regarding "legal entity" with the language used in section 1876 of the Social Security Act to describe the organizational structure of CMPs.

This amendment allows the HMO to set up a non-federally qualified health benefit plan without undergoing the time and expense of establishing a separate corporation.

The Committee does not anticipate that DHHS will have difficulty implementing this provision. DHHS can use the same approach it uses for a CMP review, which is to look to the distinct component of the entity to determine whether the delivery system requirements are met and to the entire entity to determine if the financial requirements are satisfied.

Under Section 1310 of the existing HMO law, most employers are required to offer federally HMOs where such HMOs exist. If a federally qualified HMO uses the new provision to operate lines of business that include other health benefits plans, an employer offering the HMO would be required to offer only the federally qualified HMO benefit plan.

Section 3 and 4. Deductibles and physician services

Current law.—Section 1301(b)(3) requires that all basic health services provided by physicians be provided through staff members of the HMO, a medical group, an individual practice association, or physicians under contract to the HMO. Section 1301(b)(1) allows HMOs to charge "national payments" in addition to any premium. Department of Health and Human Services regulations have interperted this statutory language to allow some copayments but no deductibles.

The bill.—Section 1301(b)(3) is amended to apply the requirement for formal or contractual arrangements with physicians only to the major portion of the HMO's doctors. The effect is to allow an HMO to permit members to use some fee-for-service doctors who are not under contract to the HMO and who are chosen by the members at the time they need service. Section 1301(b)(1) is amended to permit an HMO, which offers the opportunity to obtain basic health services outside the HMO under this provision, to require a reasonable deductible for those out-of-plan service.

Committee views.—Reimbursement for out-of-plan services is not now permitted except in the case of emergency, unusual or infrequently used services. Thus, under current law, if HMO members wish to obtain their basic health services from an outside physician, the HMO cannot pay for the visits. HMOs should have the

option of allowing their members to seek outside care on an occasional basis.

The amendment in Section 4 would enable an HMO to develop and offer a health benefits package permitting up to 10 percent of basic physician services to be provided by physicians not affiliated with the HMO. This would allow an HMO to develop a health benefits package which permits its members to go "out-of-plan" for certain services and be reimbursed for them. The amendment would allow an HMO to create a "self-referral option" enabling the HMO member to use a non-HMO physician occasionally, potentially enhancing the member's satisfaction with the HMO.

The Committee is concerned, however, that HMOs would lose their essential character if they did not themselves provide the preponderance of their members' basic health services. To address this concern, the Committee adopted an amendment setting an upper limit on the amount of outside plan care that an HMO can provide. At least 90 percent of all basic physician services would continue to be provided through physicians directly affiliated with the HMO.

Section 3 of the bill would permit an HMO to establish a reasonable deductible to be applied to "out-of-plan" services provided by physicians who are not affiliated with the HMO. Copayments could also be applied as allowed under existing law. A reasonable deductible is one that would create reasonable financial incentives for HMO members to use physicians affiliated with the HMO rather than out-of-plan physicians.

Section 5(a). Risk of insolvency

Current law.—Section 1301(c)(1) requires each health maintenance organization to have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary.

The bill.—Section 5(a) would make it clear that the Secretary must take into consideration the financial condition of affiliated organizations which own an HMO in determining whether such HMO has met the fiscal soundness test of Section 1301(c)(1).

Committee views.—Currently the Secretary looks to the financial condition of affiliated organizations in determining whether individual HMOs meet the solvency requirement of Section 1301(c)(1)(A) but it is the Committee's understanding that the Department has taken the position that it lacks the authority to use a similar standard in applying the fiscal soundness test of that section.

In the Committee's view, such disparate application of the authority granted in 1301(c) was never the intent of Congress, and such anomalous results need not occur in the future. To that end, the amendment requires the Secretary to consider the financial condition of affiliated organizations which own an HMO in making fiscal soundness determinations under Section 1301(c)(1)(A). The Committee believes this change in the law will enable the Secretary to provide additional protection for beneficiaries in cases where affiliated organizations are willing and, in the Secretary's view, able to assure the fiscal soundness of individual HMOs.

Section 5(b). Repeal

Current law.—Section 1301(c)(5) dictates a variety of requirements for the board of directors of the HMO, or in the case of a public entity which operates an HMO, for the advisory body.

The bill.—These requirements are repealed.

Section 6. Definitions

Section 6(a). Organ transplants

Current law.—Before 1986, HMOs were required to provide as a medical service any organ transplant which was determined by the Secretary of Health and Human Services not to be experimental. Section 812(b) of the "HMO Amendments of 1986" changed this requirement so that the only organ transplants that are now mandated are those which the Secretary had determined, by April 15, 1985, were no longer experimental. The provision in the HMO Amendments of 1986 is in effect only until April 1, 1988.

The bill.—The April 1, 1988, repeal date in Section 812(b) is eliminated.

Committee views.—The effect of this change is that current policy will continue beyond April 1, 1988. The current policy is that HMO must offer those organ transplants which were required to be offered on April 15, 1985. All other transplants may be offered at the discretion of the HMO.

If only HMOs, and not other health insurance companies, are required to provide all new transplants as soon as they are not considered experimental, HMOs will experience serious adverse selection by people anticipating the need for such transplants. Congress agreed to put HMOs and other health benefits plans on an equal footing with regard to transplants for a provisional period. The Committee feels that the policy currently in effect represents the right policy and should be made permanent.

Section 6(b). Community rating

Current law.—Section 1302(8)(C) authorizes HMO's to establish their premiums in two ways—community rating and community rating by class, which allows for adjustments for factors such as the age and sex distribution of enrollees.

The bill.—Section 5(b) of the bill would modify the definition of community rating to permit rates to be fixed for individuals and families of a group on the basis of the organization's revenue requirements for providing services to the group.

Committee views.—Employers want HMO's to be able to tailor their rates to specific groups. In particular, large employers who feel that their healthiest workers tend to choose HMO's want to be able to negotiate a rate with the HMO that is specific for them. The bill would permit a premium to be set for a specific group (such as teachers in a school district). But, the amendment would not permit "experience rating" as practiced by indemnity carriers. When insurance companies experience rate they may adjust their premiums at the end of the policy year based on the actual use of health care services by enrollees. Under this provision, the HMO's premium for a group would be set at the beginning of the year and would not be adjusted at the end of the year based on actual expe-

rience. HMO's would still be "at risk" for the cost of all care in excess of premium for all enrolled members from the group.

This amendment would allow an HMO to adopt a system of rating called "adjusted community rating." This rating methodology is similar to that used by HMO's which have signed Medicare risk contracts under Section 1876 of the Social Security Act. Under this provision, HMO's could determine their rates for a group based on the relationship of the group's specific utilization and intensity of service compared to overall HMO member utilization and intensity patterns. The HMO must continue to be "at risk" for providing care at that prospectively determined rate and cannot retrospectively adjust rates based on actual utilization or intensity of services.

If an HMO uses this new rating methodology, the HMO shall disclose, upon request, to the entity with which it contracts the method and data used in calculating the proposed rate.

The HMO's use of this provision is restricted with regard to groups of less than 100 persons. To protect small groups against dramatic increases in their premiums, the Committee adopted an amendment that limits the HMO to a premium not more than 10 percent over the community rate, in the case of a group with 100 or less employees. This limitation was adopted by the Committee to assure that small groups would continue to have access to an HMO without significant financial barriers. The Committee notes that the general provisions which have been developed for community rating and community rating by class, such as differentials to reflect compositing or different administrative costs, apply to this new rating option.

Section 7. Employees health benefits plans

Current law.—As noted above, Section 1310 of the HMO law requires that any health benefits plan offered by an employer to its employees include the option of membership in qualified HMO's. Federal regulations promulgated shortly after passage of the Act have interpreted the Act as requiring that an employer's contribution to a federally qualified HMO be equal, dollar-for-dollar, to the largest contribution made by the employer on behalf of an employee to any non-HMO alternative health benefit plan offered by the employer, up to, but not exceeding, the HMO's premium.

The bill.—Section 1310(c) is amended to require that employer contributions on behalf of employees who enroll in an HMO not "financially discriminate" against those employees.

Committee views.—Some employers, particularly large ones, have determined that their healthiest employees enroll in HMO's and use far fewer services than their employees who remain in the employer's indemnity and self-insurance plans. They argue that HMO's engage in "shadow-pricing" their premiums based on what the employer pays or contributes to other health benefits plans, instead of basing premiums on actual HMO costs. Employers want, and HMO's are willing to accept, more flexibility so that their contributions toward HMO premiums are determined on some basis other than "dollar-for-dollar" equality with other plan contributions.

The Committee believes that the existing regulations requiring equal employer contributions are consistent with current law, but in some circumstances are potentially unfair to employers. At the same time the Committee believes that providing a statutory standard by which to measure employer contributions to HMOs is essential. The Committee chose the term "financially discriminate" and specified in the bill that the employer's contribution would not be considered to be financially discriminatory if the method for determining the contributions on behalf of all employees is resonable and assures employees a fair choice among health benefit plans.

The new standard enhances employers' flexibility in determining their contributions to HMOs while protecting employees and HMOs from discriminatory and unfair contribution practices. The Committee expects that the Department of Health and Human Services will write regulations permitting a range of options. The following are examples of some of the methods that an employer may choose in making contributions that would meet this new standard.

1. The employer could follow the practice permitted under the existing regulations of contributing to the HMO the same amount it contributes to the non-HMO alternative. For example, an employer that contributes $80 per month on behalf of each employee who joins an indemnity plan could pay the same amount on behalf of each employee who joins the HMO.

2. Employer contributions could reflect the composition of enrollees according to attributes such as age, sex, family status, prior experience in a non-HMO alternative plan, and other factors that are reasonable predictors of utilization, experience, costs, or risk. For each enrollee in a given class (based on those attributes), the employer would contribute an equal dollar amount, regardless of the plan that an employee chooses. To illustrate, one such class might be single males under the age of 30. If the employer's cost for that class in an indemnity or self-insurance plan is $60, the employer's contribution for HMO enrollment for each employee in that particular class would be $60. The employer would follow this methodology for each of the other classes. By calculating the contribution for HMO enrollment for each class in this way, the employer would determine its total payment on behalf of all employees enrolling in the HMO.

3. Some employers are concerned that when the HMO plan is available at no or nominal cost, employees may have an incentive to select the "free" HMO plan even though they were covered under a health benefits plan offered by their spouse's employer. In addition, as part of their employee benefits philosophy, other employers believe that all employees should contribute to their health care plan regardless of type. In such cases, if employees are required to contribute to a non-HMO plan, an employer could require employees to make a reasonable minimum contribution to an HMO. A contribution that did not exceed 50 percent of the employee contribution to the principal non-HMO alternative plan would be reasonable in such a situation. To illustrate, assume that the HMO's premium is $80, the alternative plan's premium is $100, and the employer contributes $80 on behalf of each employee who participates in the alternative plan. In such a case, employees who

join the HMO have no out-of-pocket costs while employees who remain with the alternative plan would contribute $20. If the employer had a policy requiring a minimum employee contribution for health benefits, it would be reasonable for the employer to require employees who enroll in the lower cost plan, in this example the HMO, to pay an amount not in excess of $10, which is 50 percent of the employee contribution to non-HMO alternative.

4. Employer contributions could be made on a percentage basis whereby the employer pays the same percentage of the premium of each health plan the employer offers. For example, if an employer paid 90 percent of the premium of each non-HMO health plan the employer offered, the employer would be permitted to pay 90 percent of the premium of the HMO alternative.

5. The amendment would also permit employers and HMOs to negotiate contribution arrangements which are mutually acceptable. Such arrangements would be deemed to satisfy the standard established by this provision.

Section 8. Restrictive State laws

Current law.—Section 1311 prohibits states from imposing a variety of requirements on HMOs.

The bill.—Section 1311 is amended to prohibit a state from establishing a requirement which would prohibit an HMO from complying with the requirements of Title 13.

Committee views.—Federal HMO law sets a policy that HMOs are to be encouraged and held to certain standards. State laws that are consistent with federal policy are not affected. This provision would only affect state laws that would prohibit an HMO from complying with Title XIII.

V. Committee Consideration and Action

On March 2, 1988, the Committee on Labor and Human Resources met in open session and ordered reported the bill H.R. 3235 with an amendment in the nature of a substitute, by voice vote, a quorum being present.

VI. Committee Cost Estimate

The Committee believes that the bill will have a negligible budget effect in the current and future fiscal years.

U.S. Congress,
Congressional Budget Office,
Washington, DC, March 16, 1988.

Hon. Edward M. Kennedy,
Chairman Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has reviewed H.R. 3235, entitled "Health Maintenance Organization (HMO) Amendments of 1987," as ordered reported by the Senate Committee on Labor and Human Resources on March 2, 1988. This bill makes a number of changes in the HMO law (Title XIII of the Public Health Service Act) in order to give HMOs greater flexibility in how they are organized and operated. If enacted, this bill

would allow HMOs to operate as part of a larger business and to permit enrollees to use same fee-for-service doctors for which co-payments and deductibles could be applied. HMOs would also be permitted to establish separate premiums for specific beneficiary groups, with certain protections provided for small groups. Current Department of Health and Human Service regulations require that an employer offering health benefits make a contribution for an employee enrolling in an HMO that is equal to the contribution made for an employee enrolling in any other health benefits option. This bill would remove this requirement and replace it with one requiring that an employer make a contribution for an employee's HMO enrollment at a level that does not "financially discriminate" against that employee.

Since the provisions of this bill do not effect premiums or costs of HMO services provided to Medicare or Medicaid beneficiaries, and since the provisions do not apply to Federal Employees Health Benefits Plans, CBO expects that no additional costs to the federal government would result from enactment of this legislation. While the provisions may affect the premiums charged by HMOs to state and local governments for their employees and may change contributions made by those governments on their behalf, the effects are not likely to be significant. In any event, such effects are too uncertain to make possible a definitive estimate.

If you wish further details on this estimate, please call me or have your staff contact Alan Fairbank (226–2820).

Sincerely,

JAMES BLUM,
Acting Director.

VII. REGULATORY IMPACT

By providing more flexibility to HMOs and employers to establish appropriate premiums, the legislation will reduce the current regulatory burden on such entities.

VIII. ADDITIONAL VIEWS OF SENATOR QUAYLE

I generally support the amendments to the HMO Assistance Act made by H.R. 3235 as being necessary changes to the law, adding flexibility for an evolving and expanding industry. However, I must express one key reservation: I do not think that Federal regulation and support of this industry should continue indefinately. For reasons I will address more fully below, I urge Congress to consider repealing this law within a specified time period.

THE HMO INDUSTRY IS NOW FULLY COMPETITIVE

The HMO Act of 1973 (P.L. 93–222) was passed to encourage the development of HMOs both through marketing leverage and financial support. When this bill was first considered, the private health insurance marketplace was dominated by indemnity plans, offering fee-for-service reimbursement. The 1973 Senate Report 93–129, stated that "the intent of this bill is simply to increase the degree of pluralism in a highly homogeneous industry."

Since enactment of the HMO Act, the industry has grown tremendously. When the Act was passed, there were only 72 plans with 3.5 million members. In 1987, according to the Group Health Association of America (the principal trade association for HMOs), there were more than 700 HMOs serving a total of 29 million members nationwide. Also according to the GHAA, over the past five years alone, the number of HMOs has grown by nearly 240% and HMO enrollment has grown an average of 20% a year. In 1970, HMO participants numbered only 1.8% of all privately insured individuals, compared to around 16% today.

This is very impressive growth indeed, and it has been very healthy for the insurance marketplace and for the consumer. But clearly the Federal government no longer needs to give this industry special treatment.

"DUAL CHOICE" REQUIREMENT IS OVERLY REGULATORY

Section 1310 of the HMO Act requires most employers who provide health benefits to offer their employees the option of membership in a Federally qualified HMO. Later this section of the law was interpreted through regulation to require that employers make an equal, dollar-for-dollar, premium contribution on behalf of their employees participating in an HMO as they would for employees participating in an indemnity plan.

Although H.R. 3235 repeals this "equal contribution" requirement, it still requires employers to make "nondiscriminatory" contributions to HMOs. Although these new requirements are supposed to enhance employers' flexibility in determining their contributions to HMOs, there are five examples of nondiscrimination methods from which an employer may choose, all of which are suf-

ficiently vague to require time-consuming regulatory clarifications from HHS.

I feel that this is another example of a burdensome mandate on employer-provided health insurance with which Congress has recently been so preoccupied. Like mandatory benefit coverages and mandatory continuation of coverage, these HMO requirements simply limit employers' flexibility in providing basic health benefits to their workers. HMO mandates, like other mandates, also make it more complicated, and thus more costly, for the employer, particularly the small marginal employer, to provide benefits at all.

Congress is familiar with the fact that there are 37 million uninsured; therefore we should be searching for ways to increase employer-provided health benefits, not decrease it.

Finally, the Committee views fail to provide any justification for continuing the dual choice requirements. In fact their main reason for keeping the HMO Act on the books is the need for Federal qualification of HMOs. However, current data on the HMO industry shows that a viable non-Federally qualified HMO market exists. According to InterStudy, a leading HMO think tank, the largest growth in the HMO industry has been in this area. In the first six months of 1987, enrollment in non-Federally qualified HMOs increased 14.7% compared to a 10.3% increase for Federally qualified HMOs. These facts offer further proof that the HMO Act is overly regulatory and should be repealed.

CONGRESS SHOULD SUNSET THE HMO ASSISTANCE ACT

For these reasons, I think the Congress should sunset the HMO Assistance Act in three years after the date of enactment of the amendments made by H.R. 3235.

Rather than try to repeal the law outright at this point in time, and risk hurting the development of HMOs in underserved areas, I feel that a sunset after several years is more appropriate. I also feel that HMOs and employers should be given the time to develop the new flexibilities in structure and payment afforded by H.R. 3235.

A sunset requirement is a mechanism which places the burden on the beneficiary of a given law to prove the continued need for the law. If the need is not proven, then the law is repealed. This should be the case with the HMO Act. A three year sunset will set a time certain for review and repeal, rather than allowing this authority to continue indefinitely. I intend to seek such an amendment to this law when H.R. 3235 is brought to the Senate floor.

DAN QUAYLE.

IX. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, exising law in which no change is proposed is shown in roman):

Public Health Service Act

* * * * * * *

TITLE XIII—HEALTH MAINTENANCE ORGANIZATIONS

REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

Sec. 1301. (a) For purposes of this title, the term "health maintenance organization" means a [legal entity] *public or private entity which is organized under the laws of any State and* which (1) provide basic and supplemental health services to its members in the manner prescribed by subsection (b), and (2) is organized and operated in the manner prescribed by subsection (c).

(b) A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this title, basic and supplemental health services to its members in the following manner:

(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education is fixed under a community rating sytsem; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services) except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payment shall be fixed in accordance with the regulations of the Secretary. A health maintenance organization may include a health service, defined as a supplemental health service by section 1302(2), in the basic health services provided its members for a basic health services payment described in the first sentence. *If a health maintenance organization offers to its members the opportunity to obtain*

basic health services through a physician not described in subsection (b)(3)(A), the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician. In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d)) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eighth month period beginning with the month following the month in which the entity became such a qualified health organization. The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.

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(3)(A) Except as provided in subparagraph (B), *at least 90 percent of* the services of a physician which are provided as basic health services shall be provided through—

(i) members of the staff of the health maintenance organization.

(ii) a medical group (or groups),

(iii) an individual practice association (or associations),

(iv) physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or

(v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

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(c) Each health maintenance organization shall—

(1)(A) have a fiscally sound operation, *which taking into consideration the fiscal soundness of an affiliated organization, if any, which owns such health maintenance organization, is sat-*

isfactory to the Secretary, and adequate provision against the risk of involvency which is satisfactory to the Secretary, and (B) have administrative and managerial arrangements satisfactory to the Secretary;

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[(5)(A) in the case of a private health maintenance organization, be organized in such a manner that assures that (i) at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and (ii) there will be equitable representation on such body of members from medically underserved populations served by the organization, and (B) in the case of a public health maintenance organization, have an advisory board to the policymaking body of the public entity operating the organization which board meets the requirements of clause (A) of this paragraph and to which may be delegated policymaking authority for the organization;]

[(6)]*(5)* be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

[(7)]*(6)* have organizational, arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides health review by physicians and other health professionals of the process followed in the provision of health services;

[(8)]*(7)* adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization—

(A) a contractual arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;

(B) insolvency insurance, acceptable to the Secretary;

(C) adequate financial reserve, acceptable to the Secretary; and

(D) other arrangements, acceptable to the Secretary, to protect members,

except that the requirements of this paragraph shall not apply to a health maintenance organization if applicable State law provides the members of such organization with protection for liability for payment of any fees which are the legal obligation of such organization; and

[(9)]*(8)* provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics, and other information (which the Secretary shall publish and disseminate on an annual basis and which the health

maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

DEFINITIONS

SEC. 1302. For purposes of this title:
(1) * * *

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(8)(A) * * *

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(C) A system of fixing rates of payment for health services may provide that the rates shall be fixed for individuals and families by groups. Except as authorized in subparagraph (D), such rates must be equivalent for all individuals in the same group and for all families of similar composition in the same group. If a health maintenance organization is to fix rates of payment for individuals and families by groups, it shall—

[(i) classify all of the members of the organization into classes based on factors which the health maintenance organization determines predict the differences in the use of health services by the individuals or families in each class and which have not been disapproved by the Secretary.

[(ii) determine its revenue requirements for providing services to the members of each class established under clause (i), and

[(iii) fix the rates of payment for the individuals and families of a group on the basis of a composite of the organization's revenue requirements determined under clause (ii) for providing services to them as members of the classes established under clause (i).]

(i)(I) classify all of the members of the organization into classes based on factors which the health maintenance organization determines predict the differences in the use of health services by the individuals or families in each class and which have not been disapproved by the Secretary,

(II) determine its revenue requirements for providing services to the members of each class established under subclause (I), and

(III) fix the rates of payments for the individuals and families of a group on the basis of a composite of the organization's revenue requirements determined under subclause (II) for providing services to them as members of the classes established under subclause (I), or

(ii) fix the rates of payments for the individuals and families of a group on the basis of the organization's revenue requirements for providing services to the group, except that the rates of payments for the individuals and families of a group of less than 100 persons may not be fixed at rates greater than 10 per-

cent of the rate that would be fixed for such individuals and families under subparagraph (B) or clause (i) of this subparagraph.

The Secretary shall review the factors used by each health maintenance organization to establish classes under clause (i). If the Secretary determines that any such factor may not reasonably be used to predict the use of the health services by individuals and families, the Secretary shall disapprove such factor for such purpose. *If a health maintenance organization is to fix rates of payment for a group under clause (ii), it shall, on request of the entity with which it contracts to provide services to such group, disclose to that entity the method and data used in calculating the rates of payment.*

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EMPLOYEES' HEALTH BENEFITS PLANS

SEC. 1310. (a) * * *

(b) If there is more than one qualified health maintenance organization which is engaged in the provision of basic and supplemental health services in the area in which the employees of an employer [subject to subsection (a)] *or a State or political subdivision* reside and if—

(1) one or more of such organizations provides more than one-half of its basic health services which are provided by physicians through physicians or other health professionals who are members of the staff of the organization or a medical group (or groups) *and provides at least 90 percent of such services through physicians described in section 1301(b)(3)(A),* and

(2) one or more of such organizations provides its basic health services which are provided by physicians through (A) an individual practice association (or associations), (B) individual physicians and other health professionals under contract with the organization, or (C) a combination of such association (or associations), medical group (or groups), staff, and individual physicians and other health professionals under contract with the organization *and provides no more than 10 percent of such services through physicians who are not described in section 1301(b)(3)(A),*

then of the qualified health maintenance organizations included in a health benefits plan of such [employer pursuant] *employer or State or political subdivision pursuant* to subsection (a) at least one shall be an organization which provides basic health services as described in clause (1) and at least one shall be an organization which provides basic health services as described in clause (2).

(c) No employer *or State or political subdivision* shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between the employer *or State or political subdivision* and its employees. Each employer *or State or political subdivision* which provides payroll deductions as a means of paying employees' contribution for health benefits or which provides a health benefits plan to which an employee contribution is not required and which is required by subsection (a) to offer his

employees the option of membership in a qualified health maintenance organization shall, with the consent of an employee who exercises such option, arrange for the employee's contribution for such membership to be paid through payroll deductions. *If a health benefits plan offered by an employer or a State or political subdivision included contributions for services offered under the plan, the employer or State or political subdivision shall make a contribution under the plan for services offered by a qualified health maintenance organization in an amount which does not financially discriminate against an employee who enrolls in such organization. For purposes of the preceding sentence, an employer's contribution does nor financially discriminate if the employer's method of determining the contributions on behalf of all employees is reasonable and is designed to assure employees a fair choice among health benefits plans.*

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RESTRICTIVE STATE LAWS AND PRACTICES

SEC. 1311. (a) In the case of any entity—

(1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulations, or otherwise—

(A) requires as a condition to doing business in that State that medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity, [or]

(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency[, and], *or*

(E) imposes requirements which would prohibit the entity from complying with the requirements of this title, and

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SECTION 812 OF THE HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1986

SEC. 812. ORGAN TRANSPLANTS AS PART OF BASIC COVERAGE.

(a) Section 1302(1) (42 U.S.C. 300e–1(1)) is amended by inserting before the last sentence the following new sentence: "Such term includes a health service directly associated with an organ transplant only if such organ transplant was required to be included in basic health services on April 15, 1985."

[(b)(1) The amendment made by subsection (a) shall take effect on October 1, 1985, and shall cease to be in effect on April 1, 1988.

[(2) April 1, 1988, for purposes of title XIII of the Public Health Service Act, no health service directly associated with an organ

transplant shall be considered to be a basic health service if such service would otherwise have been added as basic health service between April 15, 1985, and April 1, 1988.]

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